PRESCRIPTIONMART

Custom care, done right.

MAIL ORDER PHARMACY

HOW TO GET STARTED

Taking advantage of your mail order benefit may enable you to receive up to a 90-day supply of your maintenance medication(s). Just ask your physician to write for a 90-day supply, plus additional refills (to be filled at Prescription Mart).

Online: Fill out your information using our New Patient Enrollment form by registering an account on the EmpiRx Health Member Portal at myempirxhealth.com and navigating to the Mail Order section of the app.

E-prescribe or Fax: Have your doctor e-prescribe to Prescription Mart or fax your prescription to 1-409-866-1317. Faxed prescriptions may only be sent by a doctor's office and must include patient information and diagnosis for timely processing.

Mail: Mail your 90-day prescription and completed Patient Profile and Medication Order Form with payment to PO Box 12607, Beaumont, TX 77726.

GETTING A REFILL IS EASY

Online: Log on to myempirxhealth.com to order refills and download forms.
Mail: Print an order form from our website and mail to PO Box 12607, Beaumont, TX 77726.
Phone: Call us at 1-800-713-1230 with your prescription number and payment information.

FREQUENTLY ASKED QUESTIONS

When will I receive my medication?
Shipping may take up to 14 days. In some cases, we utilize a combo of mail-order partners for expedited service. Shipping is generally free unless you want your prescription sooner or have special handling needs.

What if my medications require special handling?
If your medications need refrigeration/special handling, a team member will contact you.

How will you contact me?
We use text, email and a standard toll-free telephone number.

How do I pay for my prescriptions?
We do require payment before we ship your order (we do not bill). You can pay by personal check, money order, FSA/HRA or major credit/debit card. Please don't send cash.

How are controlled substances handled?
These prescriptions have strict guidelines. Our team will reach out to you to confirm additional details.

CONTACT US

Toll-free Phone:
1-800-713-1230

Fax:
1-409-866-1317

Customer Service:
Mon-Fri: 7a-6p CST
Sat: 8a-1p CST
(Closed major holidays)

Website:
prescriptionmartpharmacy.com

Mailing Address:
Prescription Mart
PO Box 12607
Beaumont, TX 77726

Find our Notice of Privacy Practices at **prescriptionmartpharmacy.com**
Translation Services are available for limited English proficiency patients upon request.
Prescription Readers are available for visually impaired patients upon request.

EMPIRX HEALTH
Customer-First Pharmacy Care.

NEW PRESCRIPTIONS – Mail your new prescriptions with this form. Number of **NEW** prescriptions enclosed ____

REFILLS – Indicate the prescriptions to be refilled in **Section 3**. Number of **REFILL** prescriptions requested ____

1 INSURANCE INFORMATION

Identification Number:	**Group #:**	**RxBIN #:**
Cardholder's Employer:		

If your prescriptions will be filed under workers' compensation, please provide your injury date: ___/___/___ (MM / DD / YYYY)

2 PATIENT INFORMATION

◯ Check for Spanish

Patient Name: First Middle Initial Last Suffix (JR, SR)

Date of Birth: ___/___/___ (Month / Day / Year)	◯ **Male** ◯ **Female**	◯ Check here for Easy Open caps

Home Address: Street Address Apt./Suite #

City:	**State:**	**Zip Code:**

Daytime Phone #: ( ) -	**Alternate Phone #:** ( ) -

Cell Phone #: ( ) - ◯ Check to receive text notifications & alerts

Email address: ◯ Check to receive email notifications & alerts

Doctor's Name:	**Doctor's Phone #:** ( ) -

*Please complete the following medical information if you are **a new patient** or **information has changed**:*

Drug Allergies: ◯ None ◯ Aspirin ◯ Cephalosporin ◯ Codeine ◯ Erythromycin ◯ Latex ◯ NSAIDs
◯ Peanuts ◯ Penicillin ◯ Sulfa ◯ Other: _____

Medical Conditions: ◯ None ◯ Acid Reflux ◯ Anxiety ◯ Arthritis ◯ Asthma ◯ Depression
◯ Diabetes ◯ Heart Disease ◯ High Blood Pressure ◯ High Cholesterol ◯ Migraines ◯ Osteoporosis
◯ Prostate ◯ Thyroid ◯ Other: _____

List other medications you take not filled by Prescription Mart (including over the counter supplements):

Prescription Mart may substitute FDA-approved generic medications for brand name medications unless you or your prescriber specify otherwise. If you **DO NOT** want generic medications, you must provide specific instructions (including drug names) below. **Refusal of generics may impact your copay**.

3 PRESCRIPTION REFILL INFORMATION

To request prescription **Refills**, write the **Rx Number** and **medication name** below.

1.	2.
3.	4.
5.	6.
7.	8.

4 PAYMENT INFORMATION AMOUNT AUTHORIZED: $_____

If your copay is $0, you do not need to provide payment information.

◯ Call me for payment information

◯ Check or money order enclosed (Payable to: Prescription Mart). Write your Member ID # on your check.
Prescription Mart may charge up to $25 for returned checks.

◯ Charge credit card on file

◯ Apply credit balance to this order

◯ Please charge the following card:

☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Credit card number:

Expiration Date: Billing Zip Code:

Name as it appears on card:

◯ Keep this payment method on file for future orders ◯ Use this payment method one time only

DO NOT SEND CASH.

CREDIT CARD HOLDER SIGNATURE: _____ **DATE:**_____

5 SHIPPING ADDRESS *(if different from Home Address listed in Section 2)*

First Name Middle Initial Last Name

Company Name (if applicable)

Street Address

City	State	Zip Code

◯ Check here if you would like us to use this shipping address for this order only and not future orders.

◯ Check here if you would like us to contact you to schedule expedited shipping at your expense.

If your medication(s) require special handling, a team member will reach out to you to advise when delivery is expected.

6 CERTIFICATION

I certify that the patient information entered on this form is correct and that the patient named is eligible for benefits under the Prescription Drug Program. I hereby assign to the provider pharmacy any payment due pursuant to this transaction and future transactions and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to the claim to the plan administrator, underwriter, sponsor, policy holder and employer in accordance with the Health Insurance Portability and Acountability Act (HIPAA).

PATIENT SIGNATURE: _____ **DATE:**_____